MAXIMUS Federal Services

Case Number:	CM14-0119279		
Date Assigned:	08/06/2014	Date of Injury:	03/26/2008
Decision Date:	09/16/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	07/29/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a male patient with the date of injury of March 26, 2008. A Utilization Review was performed on July 23, 2014 and recommended non-certification of 4 trigger point injections of 10cc of .25% Bupivacaine between 7/10/2014 and 7/10/2014, 1 prescription for LidoPro 121mg between 7/10/2014 and 7/10/2014, 1 prescription for Lyrica 75mg between 7/10/204 and 7/10/2014, 1 prescription for Zofran 4mg between 7/10/2014 and 7/10/2014, 1 prescription for Androgel 1% between 7/10/2014 and 7/10/2014, 1 prescription for Flexeril 7.5mg between 7/10/2014 and 7/10/2014, 1 prescription for Sonata 10mg between 7/10/2014 and 7/10/2014, and 1 prescription for Neurontin 600mg between 7/10/2014 and 7/10/2014. A Follow up Pain Management Consultation dated July 10, 2014 identifies pain in both knees. The patient also continues to complain of pain in his lower back, which radiates to both lower extremities. He is requesting trigger point injections, since it consistently provides a good week of relief enabling him to be more active and to sleep better at night. The patient states that his current medical regime enables him to function on a daily basis. Objective Findings identify examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally. He has increased muscle rigidity. There are numerous trigger points which are palpable and tender throughout the lumbar paraspinal muscles. He has decreased range of motion. Motor testing in the left lower extremity is between 4-4+/5 approximately with ankle dorsiflexors between 3-3+/5. Sensory examination is decreased along the lateral thigh and lateral calf on the left in comparison to the right. Assessment identifies lumbar myoligamentous injury with left lower extremity radicular symptoms, right femoral neck fracture status post ORIF March 27, 2008, right knee internal derangement, right shoulder rotator cuff tear, s/p arthroscopic surgery November 2008, adhesive capsulitis, right shoulder, status post arthroscopic surgery August 2009, status post ALIF L3-4 along with decompression of the left peroneal nerve with [redacted] on September 9, 2011,

status post L1-2, L2-3, L3-4, L4-5, and L5-S1 PLIF (Posterior Lumbar Interbody Fusion) June 27, 2012 with [redacted], and lumbar SCS (Spinal Cord Stimulator) implant, [redacted] August 8, 2013. Treatment Plan identifies four trigger-point injections, refill medications.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

4 Trigger Point Injections jof 10cc of 0.25% Bupivacalne: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections, Criteria for the use of Trigger point Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Trigger Point Injections.

Decision rationale: Regarding the request for 4 Trigger Point Injections of 10cc of 0.25% Bupivacalne, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Frequency should not be at an interval less than two months. Within the documentation available for review, the patient has undergone previous trigger point injections. However, there is no documentation of at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks, as a result of previous trigger point injections. In addition, there is no clarification that at least 2 months have passed since the previous injections. In the absence of such documentation, the requested 4 Trigger Point Injections of 10cc of 0.25% Bupivacalne are not medically necessary.

LidoPro 121mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Lidocaine, topical; Capsaicin, topical; Salicylate topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=ef3f3597-94b9-4865-b805-a84b224a207e.

Decision rationale: Regarding request for LidoPro, LidoPro contains Capsaicin 0.0325%, Lidocaine 4.5%, Menthol 10%, and Methyl Salicylate 27.5%. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical Lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical Lidocaine for localized peripheral pain after there has been

evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of Lidocaine cream, lotion, or gel is indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical Lidocaine preparations which are not in patch form. In addition, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Lidopro 121mg is not medically necessary.

Lyrica 75mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica (pregabalin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21 of 127.

Decision rationale: Regarding request for Lyrica, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs (Antiepilepsy drugs) depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, despite documentation that the current medication regime helps the patient function daily, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. In the absence of such documentation, the currently requested Lyrica 75mg is not medically necessary.

Zofran 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Zofran.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Antiemetics.

Decision rationale: Regarding the request for Ondansetron, California MTUS guidelines do not contain criteria regarding the use of antiemetic medication. ODG states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that Ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses.

Additionally, there are no subjective complaints of nausea in any of the recent progress reports provided for review. In the absence of clarity regarding those issues, the currently requested Zofran 4mg is not medically necessary and appropriate.

Androgel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone Replacement for Hypoganadism (related to opioids).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Testosterone.

Decision rationale: Regarding the request for AndroGel, California MTUS does not address the issue. ODG cites that testosterone replacement is recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. Within the documentation available for review, there is no documentation of a low testosterone level for which replacement would be indicated. In the absence of such documentation, the currently requested Androgel 1% is not medically necessary and appropriate.

Flexeril 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, despite documentation that the current medication regime helps the patient function daily, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril 7.5mg is not medically necessary.

Sonata 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Sonata, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Sonata treatment. Finally, there is no indication that Sonata is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Sonata is not medically necessary.

Neurontin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21 of 127.

Decision rationale: Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, despite documentation that the current medication regime helps the patient function daily, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. In the absence of such documentation, the currently requested Neurontin 600mg is not medically necessary.